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ABSTRACT

This report concerns parents who contact a mental health agency to obtain help for their children and do not cooperate with agency procedures. Some suggestions are made regarding measures for identifying cooperative and uncooperative parents. These suggestions were based on data collected while cooperation of mothers was being solicited during conduct of a secondary prevention project involving the identification of antisocial kindergarten-age boys. A "normal" control group was included. Number of excuses given by mothers predicted their lack of cooperation with the identification procedures, and cooperation with subsequent ones. (Author/DP)

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This report deals with parents who contact a mental health agency to obtain help for their children and do not cooperate with agency procedures. Some suggestions will be made regarding measures for identifying cooperative and uncooperative parents. These suggestions were based on data collected while cooperation of mothers was being solicited during conduct of a secondary prevention project involving the identification of acting-out kindergarten boys. A normal control group was included.

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Excuses and Cooperation as Possbile Measures for Identification of Clinic Dropouts[1]

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This report deals with parents who come into contact with a mental health agency to obtain help for their children and then do not cooperate with agency procedures. Some suggestions will be made regarding measures that might be useful in identifying the dropout parent and perhaps the dropout patient. Dropouts are defined for our purposes as individuals who discontinue contact with mental health agencies at any point after an initial telephone call or interview. These individuals consume large amounts of staff time and agency funds, and also pose a challenge to mental health professionals interested in serving them.

Most investigators have used the term, "dropout" to refer to the person who, after undergoing the intake interview, diagnostic evaluation, and staffing, is offered treatment and refuses it. This person is call the "pre-therapy" dropout, and is usually excluded from investigations of dropout rates (Brandt, 1965). Another type of dropout is the "in-therapy" dropout who terminates treatment after it begins. In most studies, one type is not distinguished from the other, nor is there any standard "cutoff"

number of treatment sessions beyond which termination by the patient results in his being labeled a dropout. To add to the confusion about definition, many studies differentiate the dropout patient on the basis of patient-initiated versus therapist-initiated termination of therapy, without specifying the cutoff number of sessions. Investigations of dropout rates, therefore, are not comparable, and statistics presented are difficult to interpret. With this fact in mind, Brandt (1965) compiled dropout statistics for a variety of mental health clinics. In his review of 25 studies of adult patients in individual long-term psychotherapy he reported that 50% of dropouts occurred between the third and the forty-fourth session. These studies differed widely in sample size (from 25 to 2,478) and type of clinic and patient seen. In child guidance clinics, estimates of dropout rates vary from 30% pre-therapy (Levitt, 1958) to 48% in-therapy (Tuckman and Lavell, 1959). No studies of dropout from point of first contact with a clinic have been reported, although prediction from initial contact would be most useful for alerting staff of impending discontinuation.

Investigators have been generally unsuccessful in identifying dropouts. The literature from the 1950's to the mid-60's contains some 35 articles dealing with identification of dropouts. In addition to the problem of definition of the dropout, there are two other major methodological problems that affect general conclusions drawn from a review of this body of literature.

(1) Populations for which figures are presented in various reports are not well defined, thereby limiting the practical application of the findings in any given setting.

(2) Some investigators have developed predictors which appeared to select significant numbers of dropouts from other patients at a given agency, but have failed to take the mental health agency's base rate of dropouts into account. For example, in one investigation (Kotkov and Meadow, 1953), a predictive equation using certain Rorschach variables correctly identified 81% of patients terminating before the ninth interview. A count of the actual number of patients terminating showed that 69% discontinued before the ninth interview; thus, a gain of only 12% of patients correctly identified was realized.

The present report addresses itself to identification of dropouts from evaluation at a point prior to offer of treatment. At this point, as Brandt (1965) suggested, the number of determinants of continuation in treatment is very small compared to the large number that intrude once treatment begins. For instance, choice of therapist and type of therapy do not complicate prediction of dropout. Brandt also pointed out that, while it may be useful to try to gather data on characteristics of pretherapy dropouts, there is an overwhelming problem in locating these persons for followup. It seems imperative, then, that data on these early dropouts be collected beginning with their first agency contact, and not after the dropout occurs.

METHOD

The results to be reported were based on data collected while the cooperation of mothers was being solicited during the conduct of a larger research project. The project involved the identification of acting-out or antisocial kindergarten-age boys who were low in compliance and high in deviant behavior rates as a first step toward the evaluation of a behavior modification intervention program designed as a preventive mental health attempt. A normal control group of boys was included in the project for comparison with the problem children.

In order to obtain the boys' behavior rates in their home, we invited mothers to participate in the identifcation phase of the project. The first direct contact between the project staff and the mothers was by telephone, when the staff tried to set an appointment for a home visit to discuss the possibility of their taking part in the research. During the earliest attempts to set these home visits, staff noted that several mothers made excuses about being unable to set appointments, and when they did set appointments, they often failed to keep them. After these first few disappointments, it was decided to collect data on the number of excuses given by mothers starting with the first telephone contact, and to keep a record of parent cooperation with the various phases of the project. The primary hypothesis was that the number of excuses given by mothers would predict their cooperation with the procedures involved in identifying the boys who were both deviant and normal.

Subjects

Subjects of the study were the mothers of 63 antisocial and normal boys. Only mothers contacted subsequent to the decision to collect excuses and cooperation data were included in this study. Since all communication between project staff and the boys' families was conducted through the mothers, data on their excuses will be presented; it was not possible to determine the influence of the fathers or other family members on family cooperation.

Table 1 summarizes the demographic characteristics of the intact and mother-only families, the number of children per family, and their socioeconomic level according to the Edwards Occupational Grouping Scale (Miller, 1964). In intact families, the father's occupation was scored, while the mother's occupation was scored in mother-only families. Two independent raters assigning Edwards Scale scores to the 63 families had an agreement of 93%. Mother-only families tended to be lower on the socioeconomic scale, and they also had more children than the intact families.

Table 1 about here

Procedure

The objective of the identification process was to locate boys who were antisocial at home. The strategy for identification was based on the assumption that boys who were antisocial very early in their school careers were likely to present similar problems in their homes. Identification of normal boys also was

necessary in order to obtain normative and base rate data against which to compare deviant boys.

School checklist screening. A total of 1,017 kindergarten boys were screened in a large metropolitan school district using behavior checklist scores provided by their teachers. Teachers participated on a voluntary basis, and filled out the Walker Problem Behavior Identification Checklist, or WPBIC (Western Psychological Services, Los Angeles, California) on all boys in their classrooms. (The school district administration requested the deletion of items 8, 22, 31, 37, and 44 of the WPBIC). The WPBIC Acting Out (A-O) Scale scores of the boys ranged from 0 to 17 with a mean of 2.6 and standard deviation of 4.2. A group of 90 boys with A-O scores of 10 or above, and another group of 120 boys with A-O scores between 0 and 4 were selected for further screening.

Home checklist screening. The next step was to obtain parent ratings of these 210 boys using the WPBIC in order to select those boys who were perceived as being antisocial at home by their parents. A packet requesting cooperation with the project was mailed from the central school district office to each family. The packet contained a letter from the director of special elementary projects which expressed support of the goals of the research and requested the voluntary cooperation of the family in returning the completed checklist, and a letter from the senior author which further attempted to solicit the family's cooperation in a federally-

funded research project. The letter read, "I am interested in determining how boys get along at home and at school during their kindergarten experience . . . . The research data will assist me in making recommendations to the school system on ways in which the children can be helped to have a successful school experience as they grow up." Thus, the teacher's checklist scores on the boys were not used as a basis for soliciting the parent cooperation. Instead, an appeal was made to parents to take part in the project on altruistic grounds. A material reward of $3 was offered for returning the completed checklist.

Parents of 81 of the 210 boys returned the completed checklists. The return rate, or degree of parent cooperation at this point was 39%.

Parents of 39 boys checklisted as school deviant returned, a rate of 43%, while parents of 42 school normal boys returned for a rate of 35%. Chi square analysis of the parent return rates based upon teachers' ratings of deviance and normalcy revealed that the teachers' perceptions of the boys at school were unrelated to the parents' return rates ($\chi^2 = 1.18$, $df = 1$, $p < .30$).

Identification of children checklisted deviant and normal. The WPBIC A-O Scale and Distractability Scale scores provided by the parents were tallied for each child. The correlation between these two WPBIC scales is .67 (Walker, 1971), indicating that they tap problems that tend to occur simultaneously in the same child.

A pool of boys who were above the mean on either the A-O Scale or the combined A-O and Distractability Scales of the WPBIC were designated as deviant, and boys below the mean were designated as normal. The cutoff scores did not identify boys rated as extremely deviant from others, but more stringent criteria would have resulted in severe and impractical attrition of the sample. Boys who were rated normal by both parent and teacher were designated "normals" and kept in the study for further screening by naturalistic observation.

Contact with parents for home visit. Parents of the remaining sample of 63 boys were contacted by telephone using a standard interview in order to solicit their cooperation for further evaluation of their boys. Deviant boys' parents were told that they had scored their boys as having more behavior problems than the average from approximately 81 other boys whose parents returned checklists. They were offered an opportunity to obtain a free and more extensive evaluation of the boys' current problems at home and at school. This offer was posed both as a service and a research function; they were under no obligation to cooperate and would be provided a written report of the results of the evaluation. At this point, no firm offer of treatment was made, but mothers were told that if their boy had a serious problem, they would be offered help if the investigators could provide it. Mothers of normal boys were told that, according to the home checklist scores, their children

had no more behavior problems than most boys their age, but that direct observation of normal children could provide important information that would be useful in planning treatment for children who had serious behavior problems. All mothers were offered payment of $15 upon completion of the observation series.

Following this offer, the mothers were asked to agree to set an appointment time for a home visit from a project staff member who could discuss further the details of the observations. No commitment to the observations was required of mothers at this time.

The home visit. When a staff member made a home visit, she recorded whether the family kept an appointment and the length of time she had to wait for them. There was a standard format for these visits to assure that all families received similar information and that the staff members covered all the necessary points. Prior to termination of the home visit, parents were asked to agree verbally to observations in both home and school.

The observations. Once parents verbally consented to the observations, the mother was called to set the dates of observation. These observations had to take place at the same hour each time and be completed within three weeks. Observations were conducted when: the whole family was present and in view of the observer, the television set was off, no visitors were present, and the family was not communicating with the observer during the observation period. The six 30-minute observations began with the first one for which

the family was on time. If the family was not all present within ten minutes of the appointed time, the observer left and called later to make another appointment.

Summary of identification procedures. In summary, requests made of the mothers may be divided into three phases:

Phase 1: Telephone contact. Mothers were asked to talk to staff who called by telephone to report the checklist results. They also were asked to set an appointment for the home visit.

Phase 2: Home visit. Parents were asked to be present and on time for the home visit, and to agree to the evaluation consisting of a set of observations.

Phase 3: Home observations. The entire family was asked to be present and on time for each of six home observations.

Dependent variables. The major dependent variable was the number of excuses given by each mother beginning with the first telephone contact. An excuse was defined as a verbal effort to avoid agreement with a request at the point when a request was made. Some examples of excuses were:

"I have to talk with my husband."

"I'm too busy now."

"I'm looking for a new job."

During each of ten telephone calls to ten of the mothers, a second staff member listened to the call while the first member discussed arrangements for beginning the home observations. Both

members independently wrote down the excuses given by each mother, and then counted them to determine agreement per phone call. All staff members who talked to parents checked each other's agreement and found it to be 100%.

In addition to data on excuses, a record was kept for each family on completion of each of the three phases of the identification process.

In Table 2, the mothers were divided by groups into those who completed each phase and those who did not complete each phase, and the mean number of excuses by group was presented. As shown in the table, the mean excuse rates increased for both groups as they entered each new phase. However, the mean rates for the mothers not completing each phase was markedly higher than for mothers who completed each phase. These data suggested that excuses predicted completion of each phase. At the bottom of the table, the percent of mothers completing each phase is shown. Increasing demands as each new phase was entered probably produced the increasing dropout of participating mothers.

Insert Table 2 about here

The cumulative number of excuses given by the 35 mothers who completed all three phases was 37, while the cumulative number of excuses over all phases by the seven mothers who entered but did not complete Phase 3 was 29. Thus, mothers who were likely to cooperate with all phases averaged about one excuse each, while

mothers not completing the last phase averaged about four excuses each, indicating that the more excuses mothers gave, the less the likelihood that they would proceed through the whole identification process.

The relationship between completion of each phase and the number of excuses given during the phase was determined by means of point biserial correlations. The correlation for Phase 1 was $-.82$ ($df = 62$, $p < .005$), for Phase 2 it was $-.52$ ($df = 46$, $p < .005$), and for Phase 3 it was $-.76$ ($df = 41$, $p < .005$). These large and highly significant correlations indicated that the number of excuses given by mothers predicted whether their families would drop out of a given phase or cooperate.

Finally, the records of phase completion were analysed to determine the probability that, once having completed Phase 1, a family would complete Phase 2, and having completed Phase 2, the family would complete Phase 3. The conditional probabilities were substantial: the likelihood that Phase 2 would be completed given completion of Phase 1 was .96, and the likelihood of completion of Phase 3 given Phase 2 was .78. Cooperation with each previous phase predicted cooperation with the requirements of the subsequent phase.

Cooperation related to boys' behavior problems. Comparison was made of the number of parents of school checklisted deviant and normal boys who completed Phase 3. The chi square analysis

was not significant ($\chi^2 = .14$, $p > .90$, $df = 1$). A similar comparison was made of the number of parents of home checklisted deviant boys and normal boys, and no relationship was found ($\chi^2 = .07$, $p > .95$) between family completion and the boy's behavior. These results indicated that cooperation with the entire identification process was not related to the parents' knowledge of or concern about their boy's problems.

Demographic characteristics and phase completion. The relationship between phase completion, socioeconomic level, and number of parents in the family was examined. Within the top three socioeconomic levels, 95% of the parents who entered Phase 1 completed all three phases. For families at the lower end of the scale, however, only 59% of the families entering Phase 1 completed Phase 3, and this discontinuation was especially marked for families in the lowest socioeconomic level. The most critical point for continuation was between Phases 2 and 3 for all families.

Another interesting difference in continuation was seen between intact and mother-only families. Of the 78 intact families entering Phase 1, 86% completed Phase 3, as compared to 58% of the mother-only families. A further look at the data suggested that the lowest socioeconomic level group that terminated contained more mother-only than intact families. Forty intact families began Phase 1; of these, 24 completed Phase 3 while 16 did not complete. The mean socioeconomic level score for these intact families who did

not complete was 4.0, and only four of the families had a score as low as six. Twenty-three mother-only families entered Phase 1, but 11 did not complete Phase 3. The mean socioeconomic score for these families was 5.3, and nine of the 11 mothers had the lowest socioeconomic score. These results indicate that the least affluent mother-only families had the highest risk for termination of the identification process.

DISCUSSION

The number of excuses given by mothers predicted their cooperation with each phase of this study and with completion of all three phases. Once a mother began to excuse herself as she was requested to set appointments, there was a high probability that she would not keep the appointment. These mothers also were highly likely to drop out during subsequent phases. Generally, completion of each phase predicted cooperation with the subsequent one. The cooperation of the mothers was unrelated to teacher or parent-identified behavior problems in the boys, indicating that concern for the deviant child did not influence a family's participation in the identification procedures.

These finding have evident implications for identification of clinic dropouts. For example, consider that the three phases of this study are analogous to actual clinic procedures in a mental health setting. Phase 1 could be the initial telephone call to the clinic, and would include willingness to set an intake appointment. Phase 2 could be the intake appointment itself, plus setting of the

first appointment for diagnostic evaluation and/or therapy. Phase 3 could encompass both diagnostic and therapeutic procedures. The latter analogy seems reasonable because, while in the professional's view, therapy might be an enterprise separate from diagnosis, the client might not perceive such a discernible difference. If the data of the present study were transplanted into this analogy, they would suggest that approximately 50% of clients making an initial call would not complete a diagnostic and/or therapeutic process which required six appointments. About 41% of those clients calling in would not show for the intake interview. Those clients who cooperated with the earlier procedures would cooperate with subsequent ones, but the critical point of highest dropout rate would be between the intake interview and the next appointment. These speculations must be tempered by the conditions under which the cooperation of subjects in this study was solicited; the mothers did not necessarily view their children as being in need of help, nor were they actively seeking help.

However, Phases 2 and 3 which were compared to the intake interview and additional evaluation or therapeutic appointments required only that families be at home to receive the visitors. Thus, it was more likely that parents would cooperate on the basis of the little effort required and the fact that payment was offered.

The distressing fact that the less affluent the family, the less likely they were to engage in the identification process (in spite of the offer of payment) is consistent with the findings of

other investigators (e.g., Hiler, 1958, 1959; Rubenstein and Lorr, 1956). That most of the families who discontinued were mother-only families suggests that these families may be even less accessible than intact families. The findings of this study highlight the difficulties of delivering preventive services to families of low socioeconomic status.

The obvious next step is to test the usefulness of these findings in actual clinic settings. A study exploring the value of excuses and cooperation or compliance with clinic procedures is currently underway in two clinics, one a university child study center and the other a mental health center treating adults and families. Development of data collection procedures have included: (1) documentation of steps in client-clinic contacts unique to the setting, (2) sampling of the types of excuses given by clients in these settings with the goal of developing a definition of excuses that can be reliably scored, and (3) establishment of a systematic data collection system which is not cumbersome but generates the necessary data systematically for all clients. These general guidelines can be applied in various settings to establish methods for identifying potential dropouts, which could in turn result in the development of methods for prevention of dropout, or of alternative treatment strategies.

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FOOTNOTE

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TABLE 1

Demographic Characteristics of Intact and Mother-only Families

Demographic variable	Intact families	Mother-only families	All families
Number of families	40	23	63
Number of children	118	84	202
Median	2.0	3.0	2.0
Mean	2.9	3.6	3.2
Range	1-9	1-11	1-11
Standard deviation	1.6	2.4	2.0
Socioeconomic level[a]			
Median	4.0	6.0	4.0
Mean	3.3	4.8	3.8
Range	1-6	1-6	1-6
Standard deviation	1.7	1.9	1.9

[a]Scores are based on Edwards Occupational Grouping Scale.

TABLE 2

Mean Excuse Rates by Phase

Group	Phase 1			Phase 2			Phase 3		
	$\bar{x}$	σ	N	$\bar{x}$	σ	N	$\bar{x}$	σ	N
Mothers completing the phase	.06	.25	47	.35	.88	45	.69	1.08	35
Mothers not completing the phase	2.56	1.46	16	3.00	1.41	2	4.57	1.99	7
Total mothers entering the phase			63			47			42
% mothers completing the phase			75%			71%			56%